



ISLE OF WELLNESS

New Patient Exam with Dr. Marina Mangano

Name _____ Date _____
Address _____ City _____ State _____ Zip Code _____
Primary Phone _____ Email _____
Emergency Contact Name _____ Emergency Contact Phone # _____
Date of Birth _____ Age _____ How did you find us? _____
Occupation _____ Employer _____

1. Reasons for seeking chiropractic care:

Primary Reason: _____
Secondary Reason: _____

2. Previous interventions, treatments, medications, surgery, or care you've sought for primary complaint:

3. Past Health History:

a. Previous illnesses you've had in your life:

b. Previous Injury or Trauma (including any broken bones or sprains):

c. Surgeries (surgical or cosmetic) Date and Type of Surgery:

d. Allergies:

e. Medications and Reasons for Taking:

f. Pregnancies (date of delivery) and Outcomes:

4. Family Health History:

Associated health problems of relatives:

Cause of parent's or sibling's death (Age at death) _____

5. Social and Occupational History:

Employer/ Occupation: _____

Exercise/Recreational activities: _____

Alcohol and/or drug use: _____

6. Diet and other Information:

How much water do you drink per day? _____ How many hours per night do you sleep? _____

Dietary Restrictions? _____

Do you clench/grind your teeth? _____ wear a dental splint? _____

Do you suffer from headaches? (Where/how often?) _____

Rate Sleep Quality 0-10 _____? Do you snore? _____ Do you wake up feeling refreshed? _____

Do you suffer from stress incontinence? (Urinating with sneezing, jumping, running, etc?) _____

Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've Had or currently Have

a. Musculoskeletal

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Osteoporosis | <input type="radio"/> Arthritis | <input type="radio"/> Scoliosis | <input type="radio"/> Neck pain | <input type="radio"/> Back problems | <input type="radio"/> Hip disorders | |
| <input type="radio"/> Knee injuries | <input type="radio"/> Foot/ankle pain | <input type="radio"/> Shoulder problems | <input type="radio"/> Elbow/wrist pain | <input type="radio"/> TMJ issues | <input type="radio"/> Poor posture | |

b. Neurological

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anxiety | <input type="radio"/> Depression | <input type="radio"/> Headache | <input type="radio"/> Dizziness | <input type="radio"/> Pins and needles | <input type="radio"/> Numbness | |

c. Cardiovascular

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> High blood pressure | <input type="radio"/> Low blood pressure | <input type="radio"/> High cholesterol | <input type="radio"/> Poor circulation | <input type="radio"/> Angina | <input type="radio"/> Excessive bruising | |

d. Respiratory

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Asthma | <input type="radio"/> Apnea | <input type="radio"/> Emphysema | <input type="radio"/> Hay fever | <input type="radio"/> Shortness of breath | <input type="radio"/> Pneumonia | |

e. Digestive

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Anorexia/bulimia | <input type="radio"/> Ulcer | <input type="radio"/> Food sensitivities | <input type="radio"/> Heartburn | <input type="radio"/> Constipation | <input type="radio"/> Diarrhea | |

f. Sensory

- | | | | | | | |
|--|--|--|--|--|--|----------------------------|
| Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | Had <input type="radio"/> Have <input type="radio"/> | NONE <input type="radio"/> |
| <input type="radio"/> Blurred vision | <input type="radio"/> Ringing in ears | <input type="radio"/> Hearing loss | <input type="radio"/> Chronic ear infection | <input type="radio"/> Loss of smell | <input type="radio"/> Loss of taste | |

Please list any additional symptoms that you would like the doctor to know about:

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes.

Patient or Guardian Signature _____ Date _____

DETAILED SUBJECTIVES

Please answer ALL #s for each symptom. Draw scars or painful areas on diagram.

[SYMPTOM #1]

1. The symptom(s) that have prompted me to seek care today include: _____

2. And are the result of (darken circle): An accident or injury
 Work Auto Other _____
 A worsening long-term problem
 An interest in: Wellness Other _____

3. Onset (When did you first notice your current symptoms?)

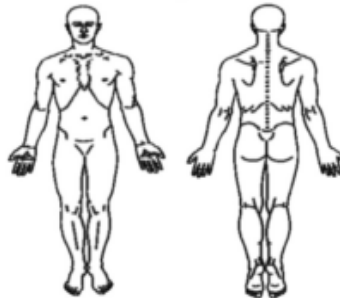
4. Intensity (How extreme are your current symptoms?)
 0 10
 Absent Uncomfortable Agonizing

5. Duration and Timing (what % of the time do you feel it?)
 Constant Comes and goes. How Often? _____

6. Quality of symptoms (What does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other _____

7. Location (Where does it hurt?)
 Circle the area(s) on the illustration.
 "O" for current condition
 "X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____
 What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Surgery Ice
- Over-the-counter drugs Acupuncture Heat
- Homeopathic remedies Chiropractic Other _____
- Physical therapy Massage _____

[SYMPTOM #2 (if applicable)]

1. The symptom(s) that have prompted me to seek care today include: _____

2. And are the result of (darken circle): An accident or injury
 Work Auto Other _____
 A worsening long-term problem
 An interest in: Wellness Other _____

3. Onset (When did you first notice your current symptoms?)

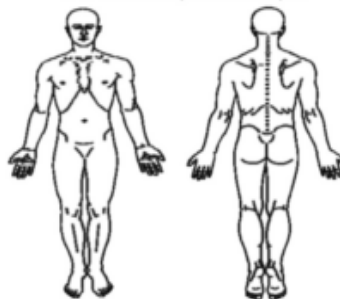
4. Intensity (How extreme are your current symptoms?)
 0 10
 Absent Uncomfortable Agonizing

5. Duration and Timing (what % of the time do you feel it?)
 Constant Comes and goes. How Often? _____

6. Quality of symptoms (What does it feel like?)

- Numbness
- Tingling
- Stiffness
- Dull
- Aching
- Cramps
- Nagging
- Sharp
- Burning
- Shooting
- Throbbing
- Stabbing
- Other _____

7. Location (Where does it hurt?)
 Circle the area(s) on the illustration.
 "O" for current condition
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8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

What tends to worsen the problem? _____
 What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Surgery Ice
- Over-the-counter drugs Acupuncture Heat
- Homeopathic remedies Chiropractic Other _____
- Physical therapy Massage _____

INFORMED CONSENT- CHIROPRACTIC

By signing below, you agree to the following:

Within the practice of chiropractic and other manual therapies there are some risks during examination and treatment procedures including, but not limited to, temporary soreness, bruising, fractures, disc injuries, dislocations, sprains and increased symptom or pain, or no improvement of symptoms or pain. A rare but serious risk associated with neck manipulation is stroke.

The Doctor of Chiropractic or office staff is not able to anticipate all the risks and complications of care but relies on clinical judgment based on all of the facts known at the time of the procedure to make decisions that are in the best interest of the patient. There are no guaranties or assurances concerning the intended results of the treatment.

As an involved patient, you have the right to be informed about your condition and the recommended chiropractic procedures to be used, so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. Together, we will create a comfortable and safe practice that matches your preferences.

I consent to providing Dr. Marina Mangano with an updated and honest medical history. I recognize that care will include close contact and that this consent covers the entire course of treatment.

I consent to this treatment. I do not consent to this treatment

Name: _____ Signature: _____ Date: _____

For a **minor or person represented by another party**, please sign on their behalf and state relationship.

Name: _____ Signature: _____ Date: _____

Relationship: _____

PAYMENT POLICY

Dr. Mangano Self-Pay Prices

Initial Office Examination (50 min)	\$120.00
Follow-Up Treatments (20 min)	\$75.00
Mobile Chiropractic (30 min)	\$100.00
Private Yoga Sessions (60 min)	\$85.00
Mobile Yoga Sessions (60 min)	\$100.00

SELF-PAY POLICY

As a self-pay patient, I understand Dr Mangano will NOT be filing/submitting/billing any treatments to my medical health insurance because she is not contracted with my health insurance company at this time.

INSURANCE POLICY

Dr. Mangano is only in-network with Horizon BCBCNJ. She will call my insurance company to receive benefits and an EOB **ESTIMATE**. It is a summary of my benefits and **not a guarantee of payment from my insurance carrier**. Please ask for an explanation of insurance benefits if unclear. I understand that through utilizing my insurance carrier, I am responsible for my annual health insurance deductible, co-pays, and/or co-insurance. After maximum visits per year, my carrier may not cover maintenance care and self-pay/cash arrangement will be made.

CANCELLATION POLICY

In an effort to give best quality care, the doctor spends 60 minutes with the patient for the initial exam and 20 minutes with the patient for follow-up visits. Out of courtesy to the doctor, staff, and other patients, **please only make appointments that you are able to keep**. Dr. Mangano has a 24-hour cancellation policy.

Cancellation Policy: We require 24 hours to cancel or reschedule an appointment; otherwise a \$50 cancellation fee or a \$75 no-show fee will be applied to your account.

I understand that by signing below I accept the financial arrangements. Payment is due at time that services are rendered unless financial arrangements have been made with the doctor. If the patient is a minor, a parent must either be present at each appointment or provide the patient with funds to pay at the time services are rendered. Please sign that you understand and agree to the above policies.

Patient's Name (signature)

Date

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction of other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, legal proceedings, and law enforcement. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient or Representative

Date

Printed Name